# MEDICAL REPORT FOR CHILD PLACING AGENCIES / RESIDENTIAL CHILD CARE FACILITIES

**Name**_____**Date of Birth**_____

**Address**_____

**Employment** Agency / Facility Name _____

Position _____

To the Examining Physician:

This examination is needed to determine my physical, psychological, and emotional ability to care for children and perform services in a child placing agency / residential child care facility. I hereby authorize you to furnish a report of my examination to the above-named agency / facility.

Signature _____ Date _____

**Tests** (Initial TB test to be completed with repeat test every two years if no extenuating circumstances exist)

Date and result of Intradermal Tuberculin Test (Mantoux)_____

If Mantoux was positive, date and result of chest x-ray _____

**Medications** Is this person currently taking a medication that will affect alertness, reactions, or driving skills?

☐ No ☐ Yes If "Yes," please describe _____

_____

_____

**Physical Limitations** Are there any physical limitation that may affect this person's ability to perform duties?

☐ No ☐ Yes If "Yes," please describe _____

_____

_____

**Have you observed any psychological or emotional behaviors that will limit this person's ability to care for children?**

☐ No ☐ Yes If "Yes," please describe _____

_____

_____

If this person needs a referral to another health professional, please describe in the "Comments" section.

**Comments** _____

_____

_____

In my opinion, the physical examination reveals that the above-named person is free of any infectious or contagious disease and is physically fit to care for children and perform services in a child placing agency / residential child care facility.

_____

Name of medical doctor, physician's assistant, or certified nurse practitioner completing exam **(Please print)**

_____ _____

Signature Date

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